Southwestern Ontario
Maternal, Newborn, Child and Youth Network

NAME OF HOSPITAL: _____

MATERNAL TRANSFER RECORD

Date (YYYY/MM/DD): _____

Referred By: _____ MD/RM

OB Care By: _____ MD/RM

Family MD: _____

Transfer From: (Institution) _____

Transfer To: (Institution) _____

Name of Accepting MD: _____

Send Copy of
Discharge Summary To: _____

NAME: .....

ADDRESS: .....

..... TELEPHONE: .....

SEX: ..... D.O.B. (YYYY/MM/DD) ..... PIN #: .....

OHC #: ..... Version Code: .....

RELIGION: .....

Next of Kin: _____

Telephone #:(_____) _____

Relationship: _____

REASON FOR TRANSFER

_____

ALLERGIES

☐ No Known Allergies Specify (drug, food, tape, dyes, latex, other) and reactions: _____

OBSTETRIC HISTORY

Please send Antenatal 1 & 2 ASAP and include Ultrasound Reports, Lab Data, Fetal Monitoring Strips (if indicated).

LMP: _____ EDB: _____ Weeks Gestation: _____

Gravida: _____ Term Pregnancies: _____ Premature: _____ Aborted: _____ Live: _____

Past C-Section or Uterine Surgery: _____ Incision Type: _____

Blood Group & Type: _____ RhIg: (☐ Yes ☐ No) Date: _____ Hep B: _____ Hep C: _____ HIV: _____ GB Strep: _____

LABOUR & BIRTH

Onset of Labour at: _____ Membranes Ruptured: ☐ Yes ☐ No Time: _____ Colour: _____

Cervical Exam: ____ /____/____ Contractions: _____ Frequency: _____ Duration: _____ Intensity: _____

Fetal Position: _____ Twin A: _____ Twin B: _____

FHR's: _____ Twin A: _____ Twin B: _____ ☐ DI/DI ☐ MONO/DI ☐ MONO/MONO

Maternal Vital Signs: BP____/____ Pulse: _____ Resp: _____ Temp: _____ Fetal Fibronectin: ☐ Positive ☐ Negative

MEDICATIONS

Antibiotics: _____ Date: _____ Time: _____

Steroids: _____ Date: _____ Time: _____ Tocolytic: _____ Date: _____ Time: _____

Magnesium Sulfate: _____ Date: _____ Time: _____ Other: _____ Date: _____ Time: _____

MEDICAL/SURGICAL HISTORY

_____

Regular Medications: _____

SOCIAL ISSUES

IN TRANSIT

IV: Angiocath Size: _____

TIME	FHR	PULSE	RESP	BP	CONTRACTIONS			MEDICATIONS (Dose / Route)	COMMENTS
					Frequency	Duration	Intensity		

TRANSFER INFORMATION

Departure Time: _____ Time of Arrival at Receiving Hospital: _____

Accompanied By: _____ Relationship: _____ Attendant During Transfer: _____

Signature/Status: _____ Print Name: _____

Distribution: White Copy - Sending Institution; Canary Copy - Receiving Institution